Page Number:1 Total Pages:3 Patient Name: [redacted] Date of Birth: [redacted]

Prehospital Care Report Summary

Huron Valley Ambulance

Date:09/13/2011 [redacted] **Time Zone:**America/New_York

Call Information:

Call Origin: N/A **Run Type:** Emergency (Immediate) **Disposition:** Treated / Transported
Unit #: 0115 - 115 Central **Lights/Siren:** To Scene and To Destination
Incident Loc: [redacted]
Location Type: Home / Residence
Receiving Facility: UNIVERSITY OF MICHIGAN ER
Dest. Reason: Patient /Family Choice
Loaded Mileage: 11.4
Crew Members: [redacted]

Moved to Amb By: Carried
Transport Position: Semi / Full Fowlers

 # Patients: 1
 # Patients at Scene: 1

Call Received: 2301:50
Dispatched: 2302:16
En Route: 2303:20
On Scene: 2312:19
Patient Contact: 2315:00
Left Scene: 2328:40
At Destination: 2350:43
In Service: 0019:08

Time On Scene: 16 Min
Time to Destination: 48 Min
Total Time of Run: 77 Min

Patient Information:

Name: [redacted]
Address:
Phone:
SSN:
PMH:
Comment:

DOB: [redacted]
Gender: Female
Age: [redacted]
Weight: 185.0 lbs

Ins. Type:
Ins. Name/Payer:
Policy Name:
Address:
Medicare:
Medicaid:
Policy:
Group:
Auth Signature: No
Privacy Sig: No
Unable to Sign: Yes
Refused to Sign: No
Guarantor Name:
Onset Time: 09/13/2011

Env Allergies: NKA **Med Allergies:** NKDA **Current Meds:** Uknown

Clinical:

Medical Need: Medically Necessary, Required Stretcher, Unconscious

Dispatch Reason (EMD): 31D02 - UNCONSCIOUS-EFFECTIVE BREATHING
Provider Impression: Alt. Level Conscious, Monitoring Required
Mechanism of Injury:
Chief Complaint: Unconscious
Protocol 1: ALTERED LOC - WASHTENAW
Protocol 2: GENERAL PREHOSPITAL CARE - WASHTENAW

Initial Assessment:

Airway: Patent
Breathing - Rate: Normal **Quality:** Unlabored **Lung Sounds: Left:** Clear **Right:** Clear
Skin - Color: Normal **Temp:** Normal **Condition:** Normal **Cap Refill:** <2sec **Edema:** None
Pupils - Left: Constricted **Right:** Constricted
Glasgow Coma Score - 1: E (2) + V (2) + M (5) = **9** **2:** **AVPU:** Unresponsive
Trauma Score: N/A **APGAR Score:** 1-min: 5-min: 10-min:
Rhythm 1: S. Brady. **Rhythm 2:**

Vitals:

Time	PTA	Employee	BP	Pulse	Resp.	SPO2	CO2	B.Sugar	Pain	Temp	Qty	Supply
2332		11	/			99						
2333		11	/			100						
2337		11	/	63		99						
2342		11	/	58		100						
2343		11	/	73								
2344		11	/			80						

Treatments/Medications:

Page Number:2 Total Pages:3 Patient Name: [redacted] Date of Birth [redacted] Call #:139241

Time	PTA	Employee	Treatment	Level	Medication	Dose	Unit	Route	Att	Unable
2315		S. Raus	Assessment-ALS		Oxygen (non-rebreather mask)	15.00	LPM	INH		No
2317		[redacted]	IV Start			N/A			1	Yes
2319			IV Start		Narcan (Naloxone)	2.00	mg	IV	1	No
2330			Assessment-ALS		Narcan (Naloxone)	2.00	mg	IV		No
2333			Nasal (NPA) Airway			N/A				Yes
2333			Cardiac Monitoring			N/A				No
2338					Narcan (Naloxone)	2.00	mg	IV		No
2338			12 Lead			N/A				No
	Yes		Assessment-ALS		Oxygen (non-rebreather mask)	15.00	LPM	INH		No
	Yes		Cardiac Monitoring			N/A				No

Narrative History Text:

HISTORY OF PRESENT ILLNESS: ON SEP 13 2011 WE FIND A 43 YEAR OLD FEMALE PATIENT PRESENTING UNCONSCIOUS WHICH STARTED ON SEP 13 2011.

TREATMENT(S) PRIOR TO OUR ARRIVAL: 02 AND CARDIAC MONITOR PROVIDED BY A-171

UPON ARRIVAL TO PATIENT AT 23:15:00 , THE FOLLOWING ASSESSMENT WAS COMPLETED.

RESPIRATORY SYSTEM: PATIENT'S AIRWAY : PATENT ; BREATHING RATE - NORMAL, BREATHING QUALITY - UNLABORED-; LUNG SOUNDS (L)-CLEAR (R)- CLEAR

CARDIOVASCULAR SYSTEM: SKIN COLOR -NORMAL, TEMPERATURE-NORMAL, CONDITION -NORMAL, CAP REFILL -2SEC, EDEMA -NONE - . INITIAL RHYTHM -S. BRADY.-.

NEUROLOGICAL SYSTEM: PUPILS (CONSTRICTED, (R) CONSTRICTED. MENTAL STATUS = UNCONSCIOUS. INITIAL GLASGOW - 9.

GLASCOW COMA SCALE QUALIFIER: INITIAL GCS HAS LEGITIMATE VALUES WITHOUT INTERVENTIONS SUCH AS INTUBATION AND SEDATION
PREGNANCY: UNKNOWN

THE FOLLOWING TREATMENTS AND/OR MEDICATIONS WERE PROVIDED:

ASSESSMENT-ALS OXYGEN (NON-REBREATHER MASK) 15.0 LPM INHALATION

CARDIAC MONITORING

23:15:00 ASSESSMENT-ALS OXYGEN (NON-REBREATHER MASK) 15.0 LPM INHALATION

23:17:00 IV START
SIZE:16
LOCATION: LEFT AC

23:19:00 IV START NARCAN (NALOXONE) 2.0 MG INTRAVENOUS
SIZE: 18
LOCATION: RIGHT AC

23:30:00 ASSESSMENT-ALS NARCAN (NALOXONE) 2.0 MG INTRAVENOUS

23:33:00 NASAL (NPA) AIRWAY
SIZE: 30
() LEFT, (X) RIGHT

23:33:14 CARDIAC MONITORING

23:38:00 NARCAN (NALOXONE) 2.0 MG INTRAVENOUS

23:38:39 12 LEAD

POST TREATMENT CHANGES IN PATIENT CONDITION: PT BECAME MORE RESPONSIVE TO PAIN ONLY. PT WOULD MUTTER WORDS BUT STILL REMAINED A&OX1

ADDITIONAL NARRATIVE:PT FOUND BY HER HUSBAND IN THE BASEMENT ON A BED. UPON ARRIVAL PT WAS NON RESPONSIVE AND GRUNTS AND THRASHES TO PAINFUL STIMULUS. O2 APPLIED AND PT PLACED ON THE CARDIAC MONITOR. PT IS IN A HIGH END SINUS BRADYCARDIA WITH A REGULAR RATE AND RHYTHM. IV ATTEMPTED AND PT WITHDREW FROM THE PAIN AND FIRST IV UNSUCCESSFUL. 2ND IV ATTEMPTED AND WAS SUCCESSFUL. PT WAS GIVEN 2 MG OF NARCAN WITH LITTLE CHANGE IN STATUS. PT LIFTED AND 2 PERSON CARRIED TO COT. PT CONTINUED ON 02 AND WAS LOADED TO COT. BLOOD SUGAR IS NORMAL. 12 LEAD IS NEGATIVE. PULSE OXIMETRY IS 99%. ADDITIONAL NARCAN WAS GIVEN ENROUTE WITH SLIGHT CHANGE IN RESPONSIVENESS. VITALS REMAINED STABLE BUT PT REMAINED RESPONSIVE TO PAINFUL STIMULUS ONLY. UPON ARRIVAL TO U OF M, PT TAKEN TO RECESS A. REPORT GIVEN TO RN AND PHYSICIAN STAFF. PT CARE ENDED

PATIENT MOVED TO STRETCHER BY: (2 PERSON CARRY)

PATIENT CARE TURNED OVER TO RN AT UNIVERSITY OF MICHIGAN ER ROOM # (RECESS A).

PERSONAL BELONGINGS LEFT WITH: FAMILY( ), ER STAFF( ), PATIENT( )
LIST BELONGINGS HERE: LICENSE

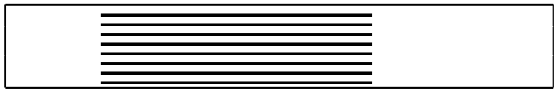
MATCHING # 460

Unable to Sign:
Unable to Sign Reason: ALOC
Authorized Representative:
Authorized Representative Signature: No
Secondary Documentation:
Secondary Documentation Signature: No
Comment:

Signature Image(s):

Authorization Signature

Privacy Notice Signature



Receiving RN / MD Signature

Technician Signature

09/13/2011 23:40

Recommended Service Level: / Dispatch Service Level: N/A

Agency Definable Field 1: Agency Definable Field 2:

Reg#: [redacted] **Name:** [redacted] **DOB:** [redacted] **Sex:** F **Age:** [redacted] **User:** ROBIE

Document Type: ED NOTE **Case Date:** 09/13/2011

Printed: 01/30/2012 20:51 PM

Re: [redacted]
Reg No: [redacted]
DOB: [redacted]

CHIEF COMPLAINT: Altered mental status.

HPI: [redacted] is a [redacted] female with no significant past medical history who is brought in by EMS after being found unresponsive. Majority of history is taken from husband, who presents shortly after patient's arrival, as patient is unable to provide due to clinical condition. Husband states that Ms. [redacted] had been doing well with no changes prior to her going to bed. They both went to bed together, and he awoke hearing her snoring very loudly. At that point he attempted to wake her, and realized that she would not awaken, and therefore, called EMS. He states the day was otherwise uneventful and she was in her usual state of health. Ms. [redacted] is very active, runs marathons and participates in many exercise programs. She went to kick boxing earlier in the evening, however, she did not note any trauma associated with that. She was complaining of no headache or pain throughout the remainder of her body when she returned. They had dinner together. She drank 1 glass of vodka cranberry and went to bed at the same time as her husband. He reports no ingestions. She is currently taking prednisone and doxycycline for a recently diagnosed poison ivy. This was diagnosed approximately 7 weeks ago when she developed a rash over her bilateral upper extremities and lower extremities. She was started on prednisone, followed by an unknown antibiotic. After no resolution, she was started on another Dosepak of prednisone with doxycycline which she is still currently on. He states the only other medications she would have access to are her Celexa and ibuprofen and tylenol in the home. She does have a history of depression; however, has never had suicidal ideation and has had no depressive symptoms recently. There were periods of time where she was not around him throughout the evening; however, very limited. No empty pill bottles found around the house by EMS or husband.

Prior to arrival by EMS, the patient was administered 6 milligrams of Narcan with minimal improvement, no other interventions prior to arrival.

PAST MEDICAL HISTORY: Depression, recent poison ivy.

SURGICAL HISTORY: None.

HOME MEDICATIONS: Celexa, prednisone, doxycycline.

ALLERGIES: No known drug allergies.

REVIEW OF SYSTEMS: Unable to be obtained due to clinical condition. Reviewed with husband, no complaints patient has commented on or that he has noted.

SOCIAL HISTORY: Is a smoker with occasional alcohol use, no history of illicit drug use per husband's report.

FAMILY HISTORY: No history of stroke, aneurysms or neurological disorders husband

is aware of.

PHYSICAL EXAM:
VITAL SIGNS: Temp 36.9, pulse 60, blood pressure 132/92, respiratory rate of 20, SpO2 98% on room air.
GENERAL: Well-developed, well-nourished female lying in bed in no acute distress; however stuporous state, is responsive to deep sternal rub.
HEENT: Atraumatic, normocephalic. Pupils with slight anisocoria. Right pupil approximately 3 millimeters and left pupil 2 millimeters, minimally reactive to light, unable to directly test extraocular movements, and no obvious abnormalities fixed or disconjugate gaze noted. Oropharynx with moist mucous membranes. No erythema or exudates.
NECK: Supple, trachea midline, carotid pulses 2+.
CARDIAC: Bradycardic with regular rhythm, no murmurs, rubs, or gallops.
PULMONARY: Clear to auscultation bilaterally with no wheezes or rhonchi.
ABDOMEN: Soft, nondistended, no reaction to palpation throughout. No organomegaly or masses palpated.
EXTREMITIES: Warm and well perfused. Distal pulses 2+ and equal. No signs of trauma. No deformities.
BACK: No external signs of trauma or deformities.
NEURO: The patient lays in bed in a stuporous state. Upon deep sternal rub when initially in the Emergency Department, she does open her eyes and responds to questions regarding if she took any ingestions by stating, my name is; however, then falls off without completing the sentence. She withdraws to pain with purposeful movement in her bilateral upper extremities and lower extremities withdraws, unclear if purposeful. Bilateral upper extremities with difficulty obtaining reflexes at brachioradialis. Motor strength appears to a full based on withdrawal and upon initial awakening with sternal rub, is moving all extremities equal; however, has no spontaneous movement without stimuli. Her lower extremities have hyperreflexive reflexes 3+, bilateral knees and patella with 3 beats of clonus bilaterally at the ankles. Babinski is upgoing bilaterally. Her ocular exam is inconsistent. Upon initial evaluation with awakening her extraocular movements appear to be intact. She has noted anisocoria which did not appear to be different than usual by her husband. No doll's eye movements; however, upon our interval exam demonstrates a disconjugate gaze with left up and out.

[redacted]